THE STATE OF TENNESSEE

REQUEST

FOR AMENDMENT

HOME AND COMMUNITY BASED SERVICES WAIVER

FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY

DISABLED (WAIVER CONTROL # 0128.90.R2A.02)

UNDER SECTION 1915 (c)

OF THE

SOCIAL SECURITY ACT

SUBMITTED FEBRUARY 26, 2007, TO:

THE UNITED STATES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO BE EFFECTIVE MAY 1, 2007

SECTION 1915(c) WAIVER APPLICATION

1. The State of Tennessee requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a. ____ Yes b. _X_ No

   If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a. ___ 3 years (initial waiver)

   b. _X_ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a. ____ Nursing facility (NF)

   b. _X_ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

   c. ____ Hospital

   d. ____ NF (served in hospital)

   e. ____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   a. ___ aged (age 65 and older)

   b. ___ disabled

   c. ___ aged and disabled

   d. _X_ mentally retarded - The individual must have mental retardation occurring before age 18 years.

e. X developmentally disabled - The individual must be age five (5) years or less and have a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in mental retardation.

f. ~~X~~ mentally retarded and developmentally disabled

g. ____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a. ____ Waiver services are limited to the following age groups (specify):

b. ____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

c. ____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d. X Other criteria. (Specify):

All individuals must meet Tennessee Medicaid financial and medical eligibility criteria for care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

e. ____ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a. X Yes b. ____ No

7. A waiver of §1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a. X Yes b. ____ No c. ____ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a. ____ Yes b. _X_ No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a. ____ Yes b. _X_ No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a. _X_ ~~Case management~~ Support Coordination

b. ____ Homemaker

c. ____ Home health aide services

d. ____ Personal care services

e. _X_ Respite ~~care~~

f. ____ Adult day health

g _X_ Habilitation

_X_ Residential habilitation

____ Day habilitation

____ Prevocational services

____ Supported employment services

____ Educational services

h. X Environmental accessibility ~~adaptations~~ modifications

i. ____ Skilled nursing

j. X ~~Transportation~~ Individual Transportation Services

k. X Specialized medical equipment and supplies and assistive technology

l. ____ Chore services

m. X Personal Emergency Response Systems

n. ____ Adult companion services

o. ____ Private duty nursing

p. ____ Family education

q. ____ Attendant care

r. ____ Adult Residential Care

____ Adult foster care

____ Assisted living

s. X Extended State plan services (Check all that apply):

____ Physician services

____ Home health care services

X Physical therapy services

X Occupational therapy services

X Speech, language, and hearing ~~and language~~ services

____ Prescribed drugs

X Other (specify):

1. Nursing Services

2. Dental Services

t. X Other services (specify):

1. Behavior Services
2. Day Services
3. Family Model Residential Support
4. Medical Residential Services
5. Nutrition Services
6. Orientation and Mobility Training
7. Personal Assistance
8. Supported Living
9. Vehicle Accessibility Modifications
10. Behavioral Respite Services
11. Transitional Case Management

u. ____ The following services will be provided to individuals with chronic mental illness:

____ Day treatment/Partial hospitalization

____ Psychosocial rehabilitation

____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. X When provided as part of respite care **or Behavioral Respite Services care** in a facility approved by the State that is not a private residence (**e.g.,** hospital, NF, foster home, or community residential facility).

b. ____ Meals furnished as part of a program of adult day health services.

c. X When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. _X_ Yes b. ____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. ____ Yes b. _X_ No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans

of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of January 1, 2005 is requested.

20. The State contact person for this request is ~~Gail Thompson, R.N.~~ Karen Carothers who can be reached by telephone at ~~(615) 741-0218~~ ~~(615) 507-6775~~ (615) 507-6778.

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____

Print Name: ~~J.D. Hickey~~ Darin Gordon

Title: Deputy Commissioner

Bureau of TennCare

Date: December 1, 2004

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

__X__ The waiver will be operated by __Division of Mental Retardation Services__, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

____ The waiver will be operated by _____, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. X ~~Case Management~~ Support Coordination

____ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. ____ Yes 2. ____ No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. ____ Yes 2. ____ No

X Other Service Definition (Specify):

Support Coordination - Support Coordination shall mean case management services that assist the enrollee in identifying, selecting, obtaining, coordinating, and using both paid services and natural supports to enhance the enrollee's independence, integration in the community, and productivity as specified in the enrollee's plan of care. Support Coordination shall be person-centered and shall include, but is not limited to, ongoing assessment of the enrollee's strengths and needs; development, evaluation, and revision of the plan of care; assistance with the selection of service providers; provision of general education about the waiver program, including enrollee rights and responsibilities; and monitoring implementation of the plan of care and initiating individualized corrective actions as necessary (e.g., reporting, referring, or appealing to appropriate entities). It shall also include at least one face-to-face contact with the enrollee per calendar month. If the enrollee receives a residential service, the Support Coordinator shall have at least one face-to-face contact with the enrollee in the enrollee's place of residence each quarter.

~~Case managers~~ Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. X Yes 2. ____ No

~~Case managers~~ Support coordinators shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. X Yes 2. ____ No

b. ____ Homemaker:

____ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

____ Other Service Definition (Specify):

c. ____ Home Health Aide services:

____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

____ Other Service Definition (Specify):

d. ____ Personal care services:

____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

____ Payment will not be made for personal care services furnished by a member of the individual's family.

____ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached.

(Check one):

____ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

____ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

____ A registered nurse, licensed to practice nursing in the State.

____ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

____ Case managers

____ Other (Specify):

3. Frequency or intensity of supervision (Check one):

____ As indicated in the plan of care

____ Other (Specify):

4. Relationship to State plan services (Check one):

____ Personal care services are not provided under the approved State plan.

____ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

____ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

____ Other service definition (Specify):

e. _X_ Respite care:

____ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

_X_ Other service definition (Specify):

Respite – Respite shall mean services provided to an enrollee when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness, or injury, or when unpaid caregivers need relief from routine caregiving responsibilities. Respite may be provided in the enrollee's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/MR, in a home operated by a licensed residential provider, or in the home of an approved respite provider. The Respite provider may also accompany the enrollee on short outings for exercise, recreation, shopping or other purposes while providing respite care.

An enrollee receiving residential services (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Respite as a service. The cost of room and board shall be excluded from Respite reimbursement if Respite is provided in a private residence. Respite shall be limited to a maximum of 30 days per enrollee per year.

Providers who receive the per diem reimbursement rate for Respite shall be responsible for the cost of any Day Services needed while the person is receiving Respite services.

An enrollee receiving Respite shall be eligible to receive Individual Transportation Services.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s). (Check all that apply):

__X__ Individual's home or place of residence

__X__ ~~Foster home~~ Family Model Residential Support

____ Medicaid certified Hospital

____ Medicaid certified NF

__X__ Medicaid certified ICF/MR

____ Group home

__X__ Licensed respite care facility

____ Other community care residential facility approved by the State that its not a private residence (Specify type):

___X__ Other service definition (Specify):

Home operated by a licensed residential provider.
Home of an approved respite provider.

f. ____ Adult day health:

____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. ____ Yes 2. ____ No

____ Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. _X_ Habilitation:

_X_ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

_X_ Residential habilitation: ~~assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.~~

~~Transportation will be provided as a component of Residential Habilitation. The cost of this transportation is included in the rate paid to providers of Residential Habilitation. The rate will not include transportation between~~

~~residential habilitation and day habilitation or community participation or supported employment services.~~

Residential Habilitation – Residential Habilitation shall mean a type of residential service having individualized services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting including direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation), household chores~~)~~ essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act. The Residential Habilitation dwelling may be rented, leased, or owned by the Residential Habilitation provider and shall be licensed by the State of Tennessee. The Residential Habilitation provider shall provide personal funds management as specified in the plan of care. Therapeutic goals and objectives shall be required for enrollees receiving Residential Habilitation. The Residential Habilitation provider shall oversee the enrollee's health care needs.

A Residential Habilitation home shall have no more than 4 residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.

The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the enrollee is not receiving Day Services or is not at school or work.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such. With the exception of Individual Transportation Services necessary for Orientation and Mobility Training or Behavioral Respite Services, an enrollee receiving Residential Habilitation shall not be eligible to receive Individual Transportation Services.

Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the enrollee's immediate family or to the enrollee's conservator.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

Residential Habilitation may be provided out-of-state under the following circumstances:

- Out-of-state services shall be for the purpose of visiting relatives or for vacations and shall be included in the enrollee's plan of care. (Trips to casinos or other gambling establishments shall be excluded.)

- Out-of-state services shall be limited to a maximum of 14 days per enrollee per year.

- The waiver service provider agency must be able to assure the health and safety of the enrollee during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state.

- During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the enrollee and must ensure that staff meet waiver provider qualifications.

- The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the enrollee while receiving out-of-state services shall be the responsibility of the enrollee and shall not be reimbursed through the waiver.

___ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

___ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

___ Individuals will not be compensated for prevocational services.

___ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

____ Educational services, which consist of special education and related services as defined in section s (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

____ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. Supported employment includes activities needed to obtain and sustain paid work by individuals receiving waiver services, including coordination, supervision, and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. ___ Yes 2. ___ No

____ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. __X__ Environmental accessibility ~~adaptations~~ modifications:

____ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

X Other service definition (Specify):

Environmental Accessibility Modifications - ~~Environmental Accessibility Modifications shall mean only those interior or exterior physical modifications to the enrollee's place of residence which are required to ensure the health, welfare, and safety of the enrollee or which are necessary to enable the enrollee to function with greater independence.~~

~~Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning; construction of an additional room) are excluded from coverage. Any modification which is not of direct medical or remedial benefit to the enrollee is excluded from coverage. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the accessibility of an enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.~~

Environmental Accessibility Modifications shall only mean:

(1) Physical modifications to the interior of an enrollee's place of residence to increase the enrollee's mobility and accessibility within the residence;

(2) Physical modifications to an existing exterior doorway of the enrollee's place of residence to increase the enrollee's mobility and accessibility for entrance into and exit from the residence;

(3) A wheelchair ramp and modifications directly related to, and specifically required for, the construction or installation of the ramp;

(4) Hand rails for exterior stairs or steps to increase the enrollee's mobility and accessibility for entrance into and exit from the residence; or

(5) Replacement of glass window panes with a shatterproof or break-resistant material when medically necessary based on a history of destructive behavior by the enrollee.

With the exception of the modifications listed in the preceding paragraph, all other physical modifications to the exterior of the enrollee's place of residence or lot (e.g., driveways, sidewalks, fences, decks, patios) are excluded from coverage. Physical modifications to garage doors for vehicles are excluded from coverage. Environmental Accessibility Modifications which are considered to be general maintenance of the residence or which are considered improvements to the residence (e.g., installation, repair, replacement, or painting of roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; construction of an additional room; installation, repair, or replacement of lights or lighting systems; installation of stairway lifts or elevators; installation of water purifiers; or furniture are excluded from coverage. Items of Specialized Medical Equipment are excluded under this definition. Modification of an existing room which increases the total square footage of

the residence is also excluded. Wheelchair ramps shall be provided for only one entrance into an enrollee's residence. Excluded are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the enrollee,

Environmental Accessibility Modifications shall be recommended by a qualified health care professional (e.g., physician, occupational therapist, physical therapist) based on an assessment of the enrollee's needs and capabilities and shall be furnished as specified in the plan of care.

To facilitate community transition of a Medicaid eligible person residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or other institutional setting who has been determined to qualify for HCBS waiver services upon discharge, Environmental Accessibility Modifications may be made to the enrollee's place of residence during the last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver. In such cases, the Environmental Accessibility Modification will not be considered complete until the date the person leaves the ICF/MR or other institutional setting and is enrolled in the waiver, and such date shall be the date of service for billing purposes.

Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per enrollee per 2 year period.

I. ____ Skilled nursing:

____ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

____ Other service definition (Specify):

j. _X_ ~~Transportation~~ Individual Transportation Services:

____ Service offered in order to enable individuals served ~~on~~ in the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

_X_ Other service definition (Specify):

Individual Transportation Services – Individual Transportation Services shall mean non-emergency transport of an enrollee to and from approved activities specified in the plan of care. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge should be utilized.

An enrollee receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training. Enrollees who receive Respite, Behavioral Respite Services, or Personal Assistance shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite, Behavioral Respite Services, or Personal Assistance is being provided.

Individual Transportation Services shall not be used for

- Transportation to and from Day Services;
- Transportation to and from supported or competitive employment;
- Transportation of school aged children to and from school;
- Transportation to and from medical services covered by the Medicaid State Plan/TennCare Program;
- Transportation of an enrollee receiving a residential service, except as specified above for Orientation and Mobility Training and Behavioral Respite Services.

Individual Transportation Services are not intended to replace services available through the Medicaid State Plan/TennCare Program.

Transportation of school age children to and from school is excluded.

k. X Specialized Medical Equipment and Supplies and Assistive Technology

____ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

X Other service definition (Specify):

Specialized Medical Equipment and Supplies and Assistive Technology: Specialized Medical Equipment and Supplies and Assistive Technology shall mean assistive devices, adaptive aids, controls, or appliances which enable an enrollee to increase the ability to perform activities of daily living or to perceive, control, or communicate with the environment and supplies for the proper functioning of such items. Specialized Medical Equipment, Supplies, and Assistive technology shall be recommended by a qualified health care professional (e.g., occupational therapist, physical therapist, speech language pathologist, physician, or nurse practitioner) based on an assessment of the enrollee's needs and capabilities and shall be furnished as specified in the plan of care. ~~Specialized Medical Equipment and Supplies and Assistive Technology may also include a face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that specialized medical~~

~~equipment and assistive technology which requires custom fitting meets the needs of the enrollee and may include training of the enrollee by a physical therapist, occupational therapist, or speech therapist to effectively utilize such customized equipment. Such assessment or training shall be limited to a maximum of 3 hours per enrollee per day.~~

~~Items not of direct medical or remedial benefit to the enrollee shall be excluded. Items that would be covered by the Medicaid State Plan/TennCare Program shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded.~~

The following items are excluded from coverage:

a. Items not of direct medical or remedial benefit to the enrollee;
b. Items that would be covered by the Medicaid State Plan/TennCare Program;
c. Prescription and over-the-counter medications;
d. Swimming pools, hot tubs, and health club memberships;
e. Elevators, stairway lifts, and lift chairs;
f. Carpets, floor pads and mats;
g. Recreational or exercise equipment;
h. Toys;
i. Furniture, lamps, and lighting;
j. Beds, mattresses, and bedding;
k. Diapers and other incontinence supplies;
l. Food and food supplements;
m. Water purifiers and humidifiers;
n. Sensory processing/sensory integration equipment or other items (e.g., ankle weights, weighted vests or blankets, therapy balls, swings, vibrators, floor mats, balance boards, brushes);
o. Supplies other than those specifically required for the proper functioning of specialized medical equipment or assistive technology within the scope of this definition;
p. Physical modification of the interior or exterior of a place of residence;
q. Physical modification of a vehicle.

When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.

Specialized Medical Equipment, Supplies and Assistive Technology is not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of $10,000 per enrollee per 2 year period.

l. ____ Chore services:

____ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

____ Other service definition (Specify):

m. _X_ Personal Emergency Response Systems (PERS)

____ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_X_ Other service definition (Specify):

Personal Emergency Response System – A Personal Emergency Response System shall mean a stationary or portable electronic device used in the enrollee's place of residence which enables the enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

n. ____ Adult companion services:

____ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

____ Other service definition (Specify):

o. ____ Private duty nursing:

____ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home. These services are provided to an individual at home or in other environments as specified in the Plan of Care.

____ Other service definition (Specify):

p. ____ Family training

____ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

____ Other service definition (Specify):

q. ____ Attendant care services:

____ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

____ Other supervisory arrangements (Specify):

____ Other service definition (Specify):

r. ____ Adult Residential Care (Check all that apply):

____ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed__). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

____ Home health care

____ Physical therapy

____ Occupational therapy

____ Speech therapy

____ Medication administration

____ Intermittent skilled nursing services

____ Transportation specified in the plan of care

____ Periodic nursing evaluations

____ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

____ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

1. Behavioral Respite Services - Behavioral Respite Services shall mean services that provide respite for an enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis. Behavioral Respite Services shall be provided in a setting staffed by individuals who have received training in the management of behavioral issues. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider. The Behavioral Respite Services provider may also accompany the enrollee on short outings for exercise, recreation, shopping or other purposes while providing Behavioral Respite Services care.

Providers who receive the per diem reimbursement rate for Behavioral Respite Services shall be responsible for the cost of any Day Services needed while the person is receiving Behavioral Respite services.

Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence. Behavioral Respite Services shall be limited to a maximum of 60 days per enrollee per year.

An enrollee receiving Behavioral Respite Services shall be eligible to receive Individual Transportation Services.

Restraints shall not be used unless recommended by a human rights committee and unless used in accordance with the approved Individual Support Plan and Division of Mental Retardation Services (DMRS) requirements.

2. **Behavior Services** - Behavior Services shall mean (1) assessment and amelioration of enrollee behavior that presents a health or safety risk to the enrollee or others or that significantly interferes with home or community activities; (2) determination of the settings in which such behaviors occur and the events which precipitate the behaviors; (3) development, monitoring, and revision of crisis prevention and behavior intervention strategies; and (4) training of caregivers who are responsible for direct care of the enrollee in the prevention and intervention strategies. Therapeutic goals and objectives shall be required for enrollees receiving Behavior Services.

   Behavior Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Training, or Speech, Language, and Hearing Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently. Behavior Services shall be provided face to face with the enrollee except ~~that enrollee-specific training of staff may be provided when the enrollee is not present.~~ for:

   (a) Enrollee-specific training of staff; and
   (b) Behavior assessment and plan development; and
   (c) Presentation of enrollee behavior information at human rights committee meetings, behavior support committee meetings, and enrollee planning meetings. Reimbursement for presentation of enrollee behavior information at meetings shall be limited to a maximum of 5 hours per enrollee per year per provider.

   Behavior assessments, behavior plan development, and presentations at meetings shall not be performed by Behavior Specialists. Reimbursement for behavior assessments shall be limited to a maximum of 8 hours per assessment with a maximum of 2 assessments per year. Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first 30 days following its approval for use shall be limited to a maximum of 6 hours. Reimbursement shall not be made for travel time to meetings and for telephone consultations, but may be made for consultations with the enrollee's treating physician or psychiatrist during an office visit when the enrollee is present.

   Behavior Services are not intended to replace services available through the Medicaid State Plan/TennCare Program.

3. **Day Services** – Day Services shall mean individualized services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities. Therapeutic goals and objectives shall be required for enrollees receiving Day Services.

   Day Services may be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites. Services may also be provided in the enrollee's place of residence if there is a health, behavioral, or other medical reason or if the enrollee has chosen retirement. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). A facility-based Day Services provider may, on an exception basis, provide facility-based Day Services in community locations other than in the provider's licensed facility. Examples of such exceptions would include Special Olympics or field trips as approved by the Day Services provider and in accordance with the Individual Support Plan.

With the exception of employment that is staff supported, Day Services shall be provided only on weekdays during the day (i.e., between the hours of 7:30 a.m. and 6:00 p.m.), as specified in the plan of care. Day Services shall be limited to a maximum of ~~6 hours per day and~~ 5 days per week up to a maximum of 243 days per enrollee per year.

Except for transportation to and from medical services otherwise covered through the Medicaid State Plan/TennCare Program, transportation that is needed during the time that the enrollee is receiving Day Services shall be a component of Day Services and shall be included in the Day Services reimbursement rate: Transportation to and from the enrollee's place of residence to Day Services shall be the responsibility of the Day Services provider. With the exception of transportation necessary for Orientation and Mobility Training, Individual Transportation Services shall not be billed when provided during the same time period as Day Services.

Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. For an enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
- Payments that are passed through to users of supported employment programs; or
- Payments for vocational training that is not directly related to an enrollee's supported employment program.

Day Services are not intended to replace services available through the Medicaid State Plan/TennCare Program.

<u>For an enrollee who is receiving facility based or community based Day Services that day, the provider may receive the per diem reimbursement for Day Services if:</u>

a. <u>The enrollee receives 6 hours of direct services comprised of community based and/or facility based Day Services. (Services provided by natural supports are not reimbursable and are excluded.); or</u>

b. <u>The enrollee receives a total of 6 hours of Day Services comprised of community based or facility based direct services plus supported employment Day Services provided as described below; or</u>

c. <u>There is documentation that the enrollee was unable to complete the full 6 hours for reasons beyond the control of the provider (e.g., sickness of the enrollee, behavioral issues involving the enrollee, refusal by the enrollee to continue, weather-related or environmental issues, medical appointments, family/conservator picked up the enrollee, enrollee or family/conservator requested 5 or fewer hours per day on an ongoing basis), and the enrollee received at least 2 hours of Day Services that day.</u>

<u>Supported employment Day Services reimbursed on a per diem basis shall be provided in accordance with the following:</u>

a. <u>A job coach employed by the Day Services provider shall be on-site at the work location and shall supervise the enrollee; or</u>

b. <u>The Day Services provider shall oversee the enrollee's supported employment services including on-site supervisors, shall have a minimum of three contacts per week with the enrollee including at least one contact per week at the work site, and</u>

shall have a job coach employed by the Day Services provider who is available on call if needed to go to the work site.

For an enrollee who is receiving supported employment Day Services that day, the provider may receive the per diem reimbursement if:

a. The enrollee receives supported employment Day Services as described above and receives either 6 hours of supported employment Day Services or 6 hours of a combination of supported employment Day Services and community based and/or facility based Day Services; or

b. There is documentation that the enrollee was unable to complete the full 6 hours of supported employment Day Services (or, if applicable, 6 hours of a combination of supported employment Day Services and community based and/or facility based Day Services) for reasons beyond the control of the provider (e.g., sickness of the enrollee, behavioral issues involving the enrollee, refusal by the enrollee to continue, weather-related or environmental issues, medical appointments, family/conservator picked up the enrollee; enrollee or family/conservator requested 5 or fewer hours per day on an ongoing basis), and the enrollee received at least 2 hours of supported employment Day Services that day.

Reimbursement for a combination of different Day Services provided on the same day shall be made in accordance with the following:

- If the enrollee receives up to 6 hours of a combination of community-based Day Services and facility-based Day Services on the same day, the reimbursement shall be the per diem reimbursement rate for the type of service (i.e., community-based or facility-based) provided to the enrollee for the greatest amount of time that day.

- If the enrollee receives more than 6 hours of a combination of community-based Day Services and facility-based Day Services on the same day, the reimbursement shall be the per diem reimbursement rate for the type of service (i.e., community-based or facility-based) provided to the enrollee for the greatest amount of time during the first 6 hours of Day Services that day.

- If the enrollee receives a combination of supported employment Day Services with either community-based Day Services or facility-based Day Services on the same day, the reimbursement shall be the per diem reimbursement rate for supported employment Day Services.

4. Family Model Residential Support – Family Model Residential Support shall mean a type of residential service having individualized services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside successfully in a family environment in the home of trained caregivers other than the family of origin. The service includes direct assistance as needed with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act. The caregivers shall be recruited, screened, trained prior to providing services, and supervised by the Family Model Residential Support provider agency. The Family Model Residential Support provider shall oversee the enrollee's health care needs.

With the exception of homes that were already providing services to 3 residents prior to January 1, 2004, a Family Model Residential Support home shall have no more than 2 residents who receive services and supports.

The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the enrollee is not receiving Day Services or is not at school or work.

Therapeutic goals and objectives shall be required for enrollees receiving Family Model Residential Support.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such. With the exception of Individual Transportation Services necessary for Orientation and Mobility Training or Behavioral Respite Services, an enrollee receiving Family Model Residential Support shall not be eligible to receive Individual Transportation Services.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling ~~and~~. Reimbursement shall not include payment made to the enrollee's parent, step-parent, spouse, child, or sibling ~~or~~. Reimbursement shall not include payment made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

Family Model Residential Support may be provided out-of-state under the following circumstances:

- Out-of-state services shall be for the purpose of visiting relatives or for vacations and shall be included in the enrollee's plan of care. (Trips to casinos or other gambling establishments shall be excluded.)

- Out-of-state services shall be limited to a maximum of 14 days per enrollee per year.

- The waiver service provider agency must be able to assure the health and safety of the enrollee during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state.

- During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the enrollee and must ensure that staff meet waiver provider qualifications.

- The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the enrollee while receiving out-of-state services shall be the responsibility of the enrollee and shall not be reimbursed through the waiver.

5. **Medical Residential Services** – Medical Residential Services shall mean a type of residential service provided in a residence where all residents require direct skilled

nursing services and habilitative services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting.

~~Medical Residential Services must be ordered by the enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services~~. The enrollee who receives Medical Residential Services shall require direct skilled nursing services on a daily basis and at a level which can not for practical purposes be provided through two or fewer daily skilled nursing visits. The enrollee's physician, physician assistant, or nurse practitioner must specify the type of skilled nursing services required.

The service includes direct assistance as needed with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

If an enrollee receiving Medical Residential Services owns or leases the place of residence, the enrollee (or the enrollee's parent, guardian, or conservator acting on behalf of the enrollee) shall have a voice in choosing other individuals with direct skilled nursing service needs who reside in the residence and the staff who provide services and supports. The enrollee shall have the right to manage personal funds as specified in the individual support plan.

A Medical Residential Service home shall have no more than 4 residents. The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports 24 hours per day when the enrollee is not ~~receiving Day Services or is not~~ at school ~~or work~~ and shall be responsible for the cost of Day Services needed by the enrollee. Therapeutic goals and objectives shall be required for enrollees receiving Medical Residential Services support.

Medical Residential Services are not intended to replace services available through the Medicaid State Plan/TennCare Program.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such. With the exception of Individual Transportation Services necessary for Orientation and Mobility Training or Behavioral Respite Services, an enrollee receiving Medical Residential Services shall not be eligible to receive Individual Transportation Services.

Reimbursement for Medical Residential Services shall not include the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the enrollee's immediate family or to the enrollee's conservator. Reimbursement shall not be made for room and board if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the enrollee, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the enrollee and who provides services to the enrollee in the enrollee's place of residence. If an enrollee owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

This service shall not be provided in schools, inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

Medical Residential Services may be provided out-of-state under the following circumstances:

- Out-of-state services shall be for the purpose of visiting relatives or for vacations and shall be included in the enrollee's plan of care. (Trips to casinos or other gambling establishments shall be excluded.)

- Out-of-state services shall be limited to a maximum of 14 days per enrollee per year.

- The waiver service provider agency must be able to assure the health and safety of the enrollee during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state.

- During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the enrollee and must ensure that staff meet waiver provider qualifications.

- The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the enrollee while receiving out-of-state services shall be the responsibility of the enrollee and shall not be reimbursed through the waiver.

6. Nutrition Services - Nutrition Services shall mean assessment of nutritional needs, nutritional counseling, and education of the enrollee and of caregivers responsible for food purchase, food preparation, or assisting the enrollee to eat. Nutrition Services must be provided in accordance with therapeutic goals and objectives specified in a plan of care developed by a dietitian or nutritionist. A dietitian or nutritionist who provides Nutrition Services must provide services within the scope of licensure and must be licensed as required by the State of Tennessee. Nutrition Services are intended to promote healthy eating practices and to enable the enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.

Nutrition Services must be provided face to face with the enrollee ~~or, for purposes of education, with the caregivers responsible for food purchase, food preparation, or assisting the enrollee to eat.~~ except for enrollee-specific training of caregivers responsible for food purchase, food preparation, or assisting the enrollee to eat and except for that portion of the assessment involving development of the plan of care.

Nutrition Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Speech, Language, and Hearing Services, Orientation and Mobility Training, or Behavior Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently.

Nutrition Services are not intended to replace services available through the Medicaid State Plan/TennCare Program.

~~Nutrition Services shall be limited to a maximum of 1.5 hours per enrollee per day.~~ Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional

Services plan development resulting from such an assessment, shall be limited to one assessment visit per month with a maximum of 3 assessment visits per year per enrollee per provider Nutrition Services other than such assessments (e.g., enrollee-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one visit per day. Nutrition Services assessments shall not be billed on the same day with other Nutrition Services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Nutrition Services unless provided by a licensed dietitian or nutritionist.

7. **Orientation and Mobility Training** – Orientation and Mobility Training shall mean assessment of the ability of an enrollee who is legally blind or severely visually impaired to move independently, safely, and purposefully in the home and community environment; orientation and mobility counseling; and training and education of the enrollee and of caregivers responsible for assisting in the mobility of the enrollee.

   Orientation and mobility training shall be based on a formal assessment of the enrollee and may include concept development (i.e. body image); motor development (i.e., motor skills needed for balance, posture and gait); sensory development (i.e. functioning of the various sensory systems); residual vision stimulation and training; techniques for travel (indoors and outdoors) including human guide technique, trailing, cane techniques, following directions, search techniques, utilizing landmarks, route planning, techniques for crossing streets, and use of public transportation; and instructional use of Low Vision devices.

   Orientation and Mobility Training shall be provided by a Certified Orientation and Mobility Specialist (COMS) who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). Orientation and Mobility Training shall be provided face to face with the enrollee ~~or, for purposes of training and education, with the~~ except for training of caregivers responsible for assisting in the mobility of the enrollee and except for that portion of the assessment involving development of the plan of care. Therapeutic goals and objectives shall be required for enrollees receiving Orientation and Mobility Training. Continuing approval of Orientation and Mobility Training shall require documentation of reassessment of the enrollee's condition and continuing progress of the enrollee toward meeting the goals and objectives.

   An enrollee receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services. Orientation and Mobility Training shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Behavior Services, or Speech, Language, and Hearing Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently.

   Orientation and Mobility Training shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

   Reimbursement for an Orientation and Mobility Training assessment with development of the Orientation and Mobility Training plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per year per enrollee per provider. Orientation and Mobility Training assessments shall not be billed on the same day with other Orientation and Mobility Training services. Orientation and Mobility Training services other than such assessments (e.g., enrollee training; enrollee-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of ~~60~~ 52 hours of services per enrollee per year. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Orientation and Mobility

Training unless provided by a Certified Orientation and Mobility Specialist (COMS) who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

8. **Personal Assistance** – Personal Assistance shall mean the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, meal preparation excluding cost of food, toileting and incontinence care, assistance with transfer and mobility), household chores essential to the health and safety of the enrollee (e.g., washing dishes; personal laundry; general housecleaning in areas of the residence used by the enrollee); budget management, ~~attending~~ supervising and accompanying the enrollee to medical appointments if needed, ~~and interpersonal and social skills building to enable the enrollee to live in a home in the community~~ and on personal errands such as grocery shopping, picking up prescriptions, paying bills; and trips to the post office. It also may include medication administration as permitted under Tennessee's Nurse Practice Act. Personal Assistance shall be provided in accordance with therapeutic goals and objectives as specified in the plan of care. Personal Assistance is a service that is provided for the direct benefit of the enrollee. It is not a service that provides assistance to other members of the household (e.g., preparation of meals for the family, family laundry). Personal Assistance staff shall not provide any personal assistance services to family members of the enrollee.

   Personal Assistance is generally delivered in the enrollee's place of residence; however, it is not restricted to the enrollee's place of residence and may be provided outside the enrollee's home in community-based settings where the Personal Assistance provider accompanies the enrollee to perform tasks and functions in accordance with the approved service definition and specified in the plan of care. Personal Assistance does not include routine provision of Personal Assistance services in an area outside the enrollee's community of residence except under exceptional circumstances and in accordance with the approved plan of care.

   Personal Assistance may be provided in the home or community; however, it shall not be provided in ~~school settings~~ schools for school-age children, to replace personal assistance or similar services required to be covered by schools, to transport or otherwise take children to or from school, ~~and shall not be provided~~ to replace ~~personal assistance~~ services ~~required to be covered by schools or services~~ available through the Medicaid State Plan/TennCare Program, or in the residence of the Personal Assistance provider except for a special event (e.g., a party) that has been authorized in the plan of care.

   Personal Assistance may be provided during the day or night, as specified in the plan of care. With the exception of Personal Assistance reimbursed on a per diem basis, Personal Assistance staff shall not be permitted to have sleep time when on duty. An enrollee who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance. Personal Assistance shall not be provided during the same time period when the enrollee is receiving Day Services. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). Personal Assistance shall not be provided in a licensed facility (e.g., a group home, boarding home, or assisted living home) when the facility's licensure category requires the provision of personal assistance or personal care services.

   Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the enrollee. The Personal Assistance provider shall not be the spouse and shall not be the enrollee's parent if the enrollee is a minor.

Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

An enrollee receiving Personal Assistance shall be eligible to receive Individual Transportation Services. The Personal Assistance provider is not obligated to provide transportation for the service recipient as part of the Personal Assistance service; however, a Personal Assistance provider who is also an Individual Transportation Services provider may bill for Individual Transportation Services for transport of the enrollee into the community.

Personal Assistance may be provided out-of-state under the following circumstances:

- Out-of-state services shall be for the purpose of visiting relatives or for vacations and shall be included in the enrollee's plan of care. (Trips to casinos or other gambling establishments shall be excluded.)

- Out-of-state services shall be limited to a maximum of 14 days per enrollee per year.

- The waiver service provider agency must be able to assure the health and safety of the enrollee during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state.

- During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the enrollee and must ensure that staff meet waiver provider qualifications.

- The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the enrollee while receiving out-of-state services shall be the responsibility of the enrollee and shall not be reimbursed through the waiver.

9. Supported Living – Supported Living shall mean a type of residential service having individualized services and supports that enable an enrollee to acquire, retain, or improve skills necessary to reside in a home that is under the control and responsibility of the ~~enrollee~~ residents. The service includes direct assistance as needed with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation (excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act. The Supported Living provider shall not own the enrollee's place of residence or be a co-signer of a lease on the enrollee's place of residence unless the Supported Living provider signs a written agreement with the enrollee that states that the enrollee will not be required to move if the primary reason is because the enrollee desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to an enrollee if such entity requires, as a condition of renting or leasing, the enrollee to move if the Supported Living provider changes. The enrollee (or the enrollee's parent, guardian, or conservator acting on behalf of the enrollee) shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports. The enrollee shall have the right to manage personal funds as specified in the Individual

Support Plan. ~~The~~ A Supported Living home shall have no more than 3 residents including the enrollee.

~~If two or more individuals share the home, each may select the Supported Living provider of their choice.~~ Therapeutic goals and objectives shall be required for enrollees receiving Supported Living. The Supported Living provider shall oversee the enrollee's health care needs.

Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must ~~have an operable smoke detector and a second means of egress~~ pass a home inspection approved by the State Medicaid Agency.

The Supported Living provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the enrollee is not receiving Day Services or is not at school or work.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such. With the exception of Individual Transportation Services necessary for Orientation and Mobility Training or Behavioral Respite Services, an enrollee receiving Supported Living shall not be eligible to receive Individual Transportation Services.

Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the enrollee and who provides services to the enrollee in the enrollee's home. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

Supported Living shall not be provided in the same residence where another family member lives, unless each such family member in the residence is also an enrollee, and ~~This service~~ shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

Supported Living may be provided out-of-state under the following circumstances:

- Out-of-state services shall be for the purpose of visiting relatives or for vacations and shall be included in the enrollee's plan of care. (Trips to casinos or other gambling establishments shall be excluded.)

- Out-of-state services shall be limited to a maximum of 14 days per enrollee per year.

- The waiver service provider agency must be able to assure the health and safety of the enrollee during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state.

- During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the enrollee and must ensure that staff meet waiver provider qualifications.

- The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the enrollee while receiving out-of-state services shall be the responsibility of the enrollee and shall not be reimbursed through the waiver.

10. **Transitional Case Management –** Case management services provided for the purpose of community transition of a Medicaid eligible person residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or other institutional setting who has been determined to qualify for HCBS waiver services upon discharge during the last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver. Transitional Case Management shall assist the enrollee in identifying, selecting, and obtaining both paid services and natural supports to enhance the enrollee's independence, integration in the community, and productivity as specified in the enrollee's transitional plan of care. Transitional Case Management shall be person-centered and shall include, but not be limited to, ongoing assessment of the enrollee's strengths and needs; development, evaluation, and revision of the transitional plan of care; assistance with the selection of service providers; provision of general education about the waiver program, including enrollee rights and responsibilities; and monitoring implementation of the transitional plan of care. Transitional case management shall include at least one face-to-face contact with the enrollee per calendar month.

    The date the person leaves the ICF/MR or other institutional setting and is enrolled in the waiver shall be the date of service for billing purposes.

11. **Vehicle Accessibility Modifications** – Vehicle Accessibility Modifications shall mean interior or exterior physical modifications (1) to a vehicle owned by the enrollee or (2) to a vehicle which is owned by the guardian or conservator of the enrollee and which is routinely available for transport of the enrollee. Such physical modifications ~~must~~ shall be limited to those which are intended to increase the enrollee's accessibility for entrance into and exit from the vehicle or to ensure the transport of the enrollee in a safe manner. Replacement of tires or brakes, oil changes, and other vehicle maintenance ~~procedures~~ or repair shall be excluded.

    ~~Vehicle Accessibility Modifications shall not replace Medicaid State Plan/TennCare Program services, and to the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service~~. Vehicle Accessibility Modifications shall be limited to a maximum of $20,000 per enrollee per 5 year period.

t. X Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached.

Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

_____Physician services

_____Home health care services

_X_Physical therapy services

Physical Therapy - Physical therapy shall mean diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Physical Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist. Physical Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the enrollee except for that portion of the assessment involving development of the plan of care.

Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).

Physical Therapy shall be provided in accordance with a treatment plan developed by a licensed physical therapist based on a comprehensive assessment of the enrollee's needs and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Physical Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Physical Therapy services shall require documentation of reassessment of the enrollee's condition and continuing progress of the enrollee toward meeting the goals and objectives.

Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language, and Hearing Services; Nutrition Services, Orientation and Mobility Training; or Behavior Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently. Physical Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis. Physical Therapy is not intended to replace services that would normally be provided by direct care staff.

Physical Therapy services are not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service.

Reimbursement for a Physical Therapy ~~assessments~~ assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of ~~3.0 hours per enrollee per day~~ one assessment with plan development per month with a maximum of 3 assessments per year per enrollee per provider. ~~and other~~ Physical Therapy services other than such assessments (e.g., enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per enrollee per day. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Physical Therapy unless provided by a licensed

physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

X Occupational therapy ~~services~~

Occupational Therapy - Occupational Therapy shall mean diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Occupational Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist. Occupational Therapy must be ordered by a physician, physician assistant, or nurse practitioner. and ~~must be provided face to face with the enrollee. Occupational Therapy~~ must be provided face to face with the enrollee except for that portion of the assessment involving development of the plan of care. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).

Occupational Therapy shall be provided in accordance with a treatment plan developed by a licensed occupational therapist based on a comprehensive assessment of the enrollee's needs and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Occupational Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Occupational Therapy services shall require documentation of reassessment of the enrollee's condition and continuing progress of the enrollee toward meeting the goals and objectives.

Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Hearing, and Language Services; Nutrition Services, Orientation and Mobility Training, or Behavior Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis. Occupational Therapy is not intended to replace services that would normally be provided by direct care staff.

Occupational Therapy services are not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service.

Reimbursement for an Occupational Therapy ~~assessments~~ assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of ~~3.0 hours per enrollee per day~~ one assessment with plan development per month with a maximum of 3 assessments per year per enrollee per provider. ~~and other~~ Occupational Therapy services other than such assessments (e.g., enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per enrollee per day. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Occupational Therapy unless provided by a licensed occupational therapist or by a licensed occupational

therapist assistant working under the supervision of a licensed occupational therapist.

X ~~Speech, hearing and language services~~ Speech, Language, and Hearing Services

Speech, Language, and Hearing Services- Speech, Language, and Hearing Services shall mean diagnostic, therapeutic, and corrective services which are within the scope of state licensure which enable an enrollee to improve or maintain current functional abilities and to prevent or minimize deterioration of chronic conditions leading to a further loss of function. Services must be provided by a licensed speech language pathologist or by a licensed audiologist. Speech, Language, and Hearing Services must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the enrollee except for that portion of the assessment involving development of the plan of care. Speech, Language, and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language, and Hearing assessments (i.e., assess and treat orders are not accepted).

Speech, Language, and Hearing Services shall be provided in accordance with a treatment plan developed by a licensed speech language pathologist or a licensed audiologist based on a comprehensive assessment of the enrollee's needs and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Speech, Language, and Hearing Services to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Speech, Language, and Hearing Services shall require documentation of reassessment of the enrollee's condition and continuing progress of the enrollee toward meeting the goals and objectives.

Speech, Language, and Hearing Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Training, or Behavior Services, unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently. Speech, Language, and Hearing Services shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis. Speech, Language, and Hearing Services are not intended to replace services that would normally be provided by direct care staff or to replace services available through the Medicaid State Plan/TennCare Program. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service.

Reimbursement for a Speech, Language, and Hearing Services ~~assessments~~ assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of ~~3.0 hours per enrollee per day~~ one assessment with plan development per month with a maximum of 3 assessments per year per enrollee per provider. ~~and other~~ Speech, Language, and Hearing Services other than such assessments (e.g., enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per enrollee per day. Speech, Language, and Hearing Services assessments shall not be billed on the same day with other Speech, Language, and Hearing Services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Speech, Language, and Hearing Services unless provided by a licensed speech language pathologist or by a licensed audiologist.

____ Prescribed drugs

__X__ Other State plan services (Specify):

1. Nursing Services

Nursing Services - Nursing Services shall mean skilled nursing services that fall within the scope of Tennessee's Nurse Practice Act and that are directly provided to the enrollee in accordance with a plan of care. Nursing Services shall be ordered by the enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services. Nursing Services shall be provided face to face with the enrollee by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse. The enrollee must require a specifically identified skilled nursing service, excluding nursing assessment and oversight, which state law requires to be performed by a nurse. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition. Nursing Services are not intended to replace services that can be appropriately provided by unlicensed direct care staff. Therapeutic goals and objectives shall be required for enrollees receiving Nursing Services.

This service shall be provided in home and community settings, as specified in the Plan of Care, excluding schools, inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). An enrollee who is receiving Medical Residential Services shall not be eligible to receive Nursing Services ~~during the hours Medical Residential Services are being provided~~.

Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the enrollee's record of medical justification for the two services to be provided concurrently.

Nursing Services are not intended to replace either intermittent home health skilled nursing visits or private duty nursing services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Nursing Services for children enrolled in the waiver are provided through the TennCare EPSDT program.

2. Adult Dental Services

Adult Dental Services – Adult Dental Services shall mean accepted dental procedures which are provided to adult enrollees (i.e., age 21 years or older) as specified in the plan of care and for which there is no coverage for adults through the Medicaid State Plan/TennCare Program. Adult Dental Services may include fillings, root canals, extractions, the provision of dentures, and other dental treatments to relieve pain and infection, but it does not include routine dental exams and cleanings or other preventive services. Anesthesia services provided in the dentist's office ~~and billed by the dentist~~ shall be included within the definition of Adult Dental Services. Adult Dental Services shall not include facility services provided in a hospital outpatient or inpatient facility ~~services~~ or

ambulatory surgical center or related anesthesiology, radiology, pathology, laboratory, or other medical services in such setting. Intravenous sedation or other anesthesia services provided in the dentist's office may be provided by and billed by the dentist or by a nurse anesthetist or anesthesiologist who meets the waiver provider qualifications. Adult Dental Services shall exclude orthodontic services.

Adult Dental Services shall be limited to adults age 21 years or older who are enrolled in the waiver. Adult Dental Services are not intended to replace services available through the Medicaid State Plan/TennCare Program. All Dental Services for children enrolled in the waiver are provided through the TennCare EPSDT program.

u. ____ Services for individuals with chronic mental illness, consisting of (Check one):

____ Day treatment or other partial hospitalization services (Check one):

____ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

____ Other service definition (Specify):

Psychosocial rehabilitation services (Check one):

Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level.

Specific psychosocial rehabilitation services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,

b. prevocational services,

c. supported employment services, and

d. room and board.

Other service definition (Specify):

Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

____ This service is furnished only on the premises of a clinic.

Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION	OTHER STANDARD
Adult Dental Services	Dentist (individual, group, or dental service agency)	Must be licensed to practice in Tennessee (TDH Rules 0460-1 & 0460-2)		
	Anesthesiologist (for dental anesthesia only)	Must be licensed to practice in Tennessee (TCA Title 63 Chapter 6)		
	Nurse Anesthetist (for dental anesthesia only)	Must be licensed by the Department of Health (TDH Rule 1200-8-34); Must be licensed to practice in Tennessee (TDH Rules 1000-1 & 1000-2)	Must be certified as a nurse anesthetist (TCA 63-7-126)	
Behavioral Respite Services	Medicaid-certified ICF/MR	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Mental Retardation Institutional Habilitation Facility		Staff must meet DMRS provider qualification and training requirements.
	Licensed respite care facility	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Mental Retardation Respite Care Services Facility		
	Licensed residential provider	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Mental Retardation Residential Habilitation Facility		

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION	OTHER STANDARD
Behavior Services	Behavior Analyst			Also see Provider Qualifications Section C entitled "Provider Requirements Applicable to Each Service."
	Behavior Specialist			Also see Provider Qualifications Section C entitled "Provider Requirements Applicable to Each Service."
Behavior Services	Waiver service agency			Must ensure that employed Behavior Analysts and Behavior Specialists have been approved by DMRS Also see Provider Qualifications Section C entitled "Provider Requirements Applicable to Each Service."
	Psychiatrist	Must be licensed to practice in Tennessee (TCA Title 63 Chapter 6)		
	Psychologist	Must be licensed to practice in Tennessee (TDH Rules 1180-1 and 1180-2; TCA Title 63 Chapter 11)		

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION	OTHER STANDARD
Day Services	Waiver service agency	Must be licensed by the Department of Mental Health and Developmental Disabilities as Mental Retardation Adult Habilitation Day Facility (TCA Title 33 Chapter 2)		
	Individual (for staff-supported employment)	Must be licensed by the Department of Mental Health and Developmental Disabilities if serving more than one individual as Mental Retardation Adult Habilitation Day Facility (TCA Title 33 Chapter 2)		
Environmental Accessibility Modifications	Individual carpenter or craftsman	Must ~~have a business license in Tennessee.~~ be licensed in accordance with the requirements of the county or city where the service will be provided.		Modifications requiring the skill of a carpenter, electrician, plumber, or other craftsman must be made by persons with sufficient skills and training to meet state and local building codes and standards.
	Waiver service agency	~~Must ensure that subcontractors have a business license in Tennessee~~. Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Supported Living Service provider or as a Mental Retardation Residential Habilitation Facility and approved by the Division of Mental Retardation Services		
	Building supplier Durable medical equipment supplier Other retail business Local contractor	Must ~~have a business license in Tennessee.~~ be licensed in accordance with the requirements of the county or city where the service will be provided.		

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION	OTHER STANDARD
Family Model Residential Support	Waiver service agency	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as Mental Retardation Placement Service provider.		
Individual Transportation Services	Individual (including a family member)	Must have a valid driver's license for transport in Tennessee.		Must maintain liability insurance.
	Waiver service agency	All drivers must have a valid driver's license of appropriate type (e.g., personal, commercial) for transport in Tennessee.		Must maintain liability insurance.
	Commercial transportation agency	Must have a business license. All drivers must have a valid driver's license of appropriate type (e.g., personal, commercial) for transport in Tennessee.		Must maintain liability insurance.
Medical Residential Services	Waiver service agency	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Mental Retardation Residential Habilitation Facility provider or a Supported Living Service provider. and ensure that employed nurses are licensed to practice in the state of Tennessee (TDH ~~1370-1~~ Rules 1000-1 & 1000-2)		

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION	OTHER STANDARD
Nursing Services	Registered nurse	Must be licensed by the Department of Health (TDH Rule 1200-8-34); Must be licensed to practice in Tennessee (TDH Rules 1000-1 & 1000-2)		An LPN must work under the supervision of a licensed RN.
	Home care organization	Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed nurses are licensed to practice in the state of Tennessee (TDH ~~1370-1~~ Rules 1000-1 & 1000-2)		
	Waiver service agency	Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed nurses are licensed to practice in the state of Tennessee (TDH ~~1370-1~~ Rules 1000-1 & 1000-2)		
Nutrition Services	Dietitian or Nutritionist	Must have a valid license to practice in Tennessee (TDH Rule 0470-1)		
	Home care organization	Must be licensed as a home care organization in Tennessee (TDH Rule 1200-8-8-.01) and ensure that employed nutritionists are licensed to practice in the state of Tennessee (TDH ~~1370-1~~ Rule 0470-1)		
	Waiver service agency	Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed nutritionists are licensed to practice in the state of Tennessee (TDH ~~1370-1~~ Rule 0470-1)		

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION	OTHER STANDARD
Occupational Therapy	Occupational therapist	Must be licensed by the Department of Health (TDH Rule 1200-8-34); Must have a valid license to practice in Tennessee (TDH Rule 1150-2)		Occupational therapist assistants must work under the supervision of a licensed occupational therapist. In order to submit claims using the special billing codes designated "for Assistive Technology/Specialized Medical Equipment", providers must obtain additional and specific approval from DMRS.
	Home care organization	Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed therapists are licensed to practice in the state of Tennessee (TDH ~~1370-1~~ Rule 1150-2)		
	Waiver service agency	Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that employed therapists are licensed to practice in the state of Tennessee (TDH ~~1370-1~~ Rule 1150-2)		
Orientation and Mobility Training	Certified Orientation and Mobility Specialist (COMS)		Must be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).	
	Waiver service agency		Must ensure that employed orientation and mobility specialists are certified by ACVREP.	

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Personal Assistance	Individual (as permitted by federal regulations)	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as Personal Assistance Service provider, if more than one individual is served.		
	Home care organization	Must be licensed as a home care organization in Tennessee (TDH Rule 1200-8-8-.01)		
	Waiver service agency	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Personal Assistance Service provider		
Personal Emergency Response System	Personal Emergency Response System vendor	Must have a business license in Tennessee		All devices must meet Federal Communications Commission, Underwriters' Laboratory, or other equivalent standards and must be monitored by trained professionals.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Physical Therapy	Physical therapist	Must have a valid license to practice in Tennessee (TDH Rule 1150-1); Must be licensed by the Department of Health (TDH Rule 1200-8-34)		Physical therapist assistants must work under the supervision of a licensed physical therapist. In order to submit claims using the special billing codes designated "for Assistive Technology/Specialized Medical Equipment", providers must obtain additional and specific approval from DMRS.
	Home care organization	Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that therapists are licensed to practice in the state of Tennessee (TDH ~~1370-1~~ Rule 1150-1)		
	Waiver service agency	Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that therapists are licensed to practice in the state of Tennessee (TDH ~~1370-1~~ Rule 1150-1)		
Residential Habilitation	Waiver service agency	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Mental Retardation Residential Habilitation Facility		

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Respite	Waiver service agency	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Mental Retardation Respite Care Services Facility		
	Medicaid-certified ICF/MR Licensed respite care facility	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Mental Retardation Institutional Habilitation Facility if an ICF/MR or as a Mental Retardation Respite Care Services Facility if not an ICF/MR.		
	Licensed residential provider	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Mental Retardation Respite Care Services Facility		
	Approved respite provider	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Mental Retardation Respite Care Services Facility if serving more than one individual		

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Specialized Medical Equipment and Supplies and Assistive Technology	Durable medical equipment supplier or other retail or wholesale business entity	With the exception of a sole source manufacturer licensed in another state, must have a wholesale or retail business license in Tennessee (to sell equipment, supplies, etc.)		Must provide basic training on operation and maintenance of the item Must honor relevant manufacturers' warranties or guarantees. Repairs must be made by persons with sufficient skills and training to perform the repairs in accordance with manufacturer's standards.
	Waiver service agency	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Supported Living Service provider, a Mental Retardation Residential Habilitation Facility, or a Mental Retardation Adult Habilitation Day Facility. Must also be approved by the Division of Mental Retardation Services.		
	~~**For assessments and training only**~~ ~~Physical Therapist~~ ~~Occupational Therapist~~ ~~Speech language pathologist~~	~~Must be licensed by the Department of Health (TDH Rule 1200-8-34);~~ ~~Physical therapists must have a valid license to practice in Tennessee (TDH Rule 1150-1); Occupational therapist must have a valid license to practice in Tennessee (TDH Rule 1150-2); Speech language pathologists must be licensed to practice in Tennessee (TDH Rule 1370-1)~~		
	~~**For assessments and training only:**~~ ~~Home care organization~~	~~Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that therapists are licensed to practice in the state of Tennessee (TDH 1370-1)~~		
	~~**For assessments and training only:**~~ ~~Waiver service agency~~	~~Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that therapists are licensed to practice in the state of Tennessee (TDH 1370-1)~~		

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Speech, Language, and Hearing Services	Speech language pathologist Audiologist	Must be licensed to practice in Tennessee (TDH Rule 1370-1); Must be licensed by the Department of Health (TDH Rule 1200-8-34)		In order to submit claims using the special billing codes designated "for Assistive Technology/Specialized Medical Equipment", providers must obtain additional and specific approval from DMRS.
	Home care organization	Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that therapists are licensed to practice in the state of Tennessee (TDH 1370-1)		
	Waiver service agency	Must be licensed by the Department of Health (TDH Rule 1200-8-34) and ensure that therapists are licensed to practice in the state of Tennessee (TDH 1370-1)		
Support Coordination	Individual Support Coordinator			Also see Provider Qualifications Section C entitled "Provider Requirements Applicable to Each Service".
	ISC service agency			

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Supported Living	Individual	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Supported Living Service provider if serving more than one person.		
	Waiver service agency	Must be licensed by the Department of Mental Health and Developmental Disabilities (TCA Title 33 Chapter 2) as a Supported Living Service provider		
Transitional Case Management	Individual Support Coordinator			Must meet the requirements for a Support Coordinator in Provider Qualifications Section C entitled "Provider Requirements Applicable to Each Service".
	ISC service agency			
Vehicle Accessibility Modifications	Auto customization shop or repair shop	Must have a business license in Tennessee		
	Auto Mechanic	Must have a business license in Tennessee		

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

General requirements for all waiver service providers (including subcontractors):

- All providers shall be at least 18 years of age.
- Staff who have direct contact with or direct responsibility for the enrollee shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.
- Any waiver service provider who is responsible for transporting an enrollee shall ensure that the driver has a valid driver's license and automobile liability insurance.
- Staff who have direct contact with or direct responsibility for the enrollee shall pass a criminal background check performed in accordance with a process approved by the Division of Mental Retardation Services.
- Staff who have direct contact with or direct responsibility for the enrollee shall not be listed in the Tennessee Nurse Aide Abuse Registry or the Tennessee Sexual Offender Registry.
- Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.
- All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

Support Coordination

The Support Coordinator must have:

1. A Bachelor's degree from an accredited college or university in a human services field; or
2. A Bachelor's degree from an accredited college or university in a non-related field and one year of relevant experience; or
3. Associate degree plus two (2) years of relevant experience; or
4. Four (4) years of relevant experience.

Support coordinators who do not have a Bachelor's degree in a human services field must be supervised by someone who does meet that qualification.

Support Coordinators must successfully complete required pre-service training courses as well as periodic in-service training and any other any re-training required to maintain approval to be a Support Coordinator.

Behavior Services

A Behavior Specialist must have a Bachelor's degree from an accredited college or university in one of the behavioral sciences or in an alternative discipline, and acceptable field work and experience equivalent to one (1) year of full-time behavioral therapy or behavioral modification.

A Behavior Analyst must have a Master's degree in behavior analysis, psychology, special education, or related field; a minimum of 12 credit hours of undergraduate or graduate level course work in behavior analysis; and a minimum of six (6) months full-time, supervised employment (or internship/practicum) in behavior analysis under the supervision of a behavior analyst. Supervision minimally consists of face-to-face meeting for the purpose of providing feedback and technical consultation at least once per week.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

____ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

__X__ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C - ELIGIBILITY AND POST-ELIGIBILITY

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1.____ Low income families with children as described in section 1931 of the Social Security Act.

2. X SSI recipients (SSI Criteria States and 1634 States).

3.____ Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4.____ Optional State supplement recipients

5.____ Optional categorically needy aged and disabled who have income at (Check one):

a.____ 100% of the Federal poverty level (FPL)

b.____% Percent of FPL which is lower than 100%.

6. X The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

X A. Yes ___B. No

Check one:

a.____ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. X Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) X A special income level equal to:

X 300% of the SSI Federal benefit (FBR)

___% of FBR, which is lower than 300% (42 CFR 435.236)

$___ which is lower than 300%

(2)___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spend down in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)___ Medically needy without spend down in 209(b) States. (42 CFR 435.330)

(5)___ Aged and disabled who have income at:

a.___ 100% of the FPL

b.___% which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. X Medically needy (42 CFR 435.320, 435.322, 435.324 ~~and 435.330)~~

8.____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--§1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the

Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. **§ 435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. X The following standard included under the State plan (check one):

(1) ___ SSI

(2) ___ Medically needy

(3) ___ The special income level for the institutionalized

(4) ___ The following percent of the Federal poverty level): ___ %

(5) X Other (specify):

200% of SSI-FBR

B. ___ The following dollar amount:
$ _____ *

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to**, **or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. ___ SSI standard

B. ___ Optional State supplement standard

C. ___ Medically needy income standard

D. ___ The following dollar amount:
$ _____ *

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ___% of ____standard.

F._X_ The amount is determined using the following formula:

Spousal impoverishment post-eligibility rules are used.

G.___ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard

B._X_ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:
$____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of ____ standard.

E.___ The amount is determined using the following formula:

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b) N/A **209(b) State, a State that is using more restrictive eligibility requirements than SSI**. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percentage of the Federal poverty level:____%

(5)___ Other (specify):

B.___ The following dollar amount:
$____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. **is equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121:

B.___ The medically needy income standard_____;

C.___ The following dollar amount:
$____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above:____% of

E.___ The following formula is used to determine the amount:

F.___ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:

$_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: ____% of _____standard.

E.___ The following formula is used to determine the amount:

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

SPOUSAL POST ELIGIBILITY

2. X The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(Check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level:
___%

(e)___ The following dollar amount
$___**

**If this amount changes, this item will be revised.

(f)____The following formula is used to determine the needs allowance:

(g) X Other (specify):

200% of the SSI-FBR

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

____ Discharge planning team

__X__ Physician (M.D. or D.O.)

__X__ Registered Nurse, licensed in the State

____ Licensed Social Worker

____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

____ Other (Specify):

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

____ Every 3 months

____ Every 6 months

__X__ Every 12 months

____ Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

____ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

__X__ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

____ Physician (M.D. or D.O.)

____ Registered Nurse, licensed in the State

____ Licensed Social Worker

____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

__X__ Other (Specify):

Qualified Mental Retardation Professional , as defined in 42 CFR 483.430(a); or

Physician (M.D. or D.O.); or

Registered Nurse, licensed in State of Tennessee.

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

____ "Tickler" file

____ Edits in computer system

__X__ Component part of ~~case management~~ Support Coordination

____ Other (Specify):

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

____ By the Medicaid agency in its central office

____ By the Medicaid agency in district/local offices

__X__ By the agency designated in Appendix A as having primary authority for the daily operation of the waiver program

____ By the case managers

____ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

____ By service providers

____ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

__X__ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

____ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

HOME AND COMMUNITY BASED SERVICES WAIVER
FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED

ANNUAL RE-EVALUATION OF LEVEL OF CARE

Name of Enrollee_____

Social Security Number_____ Date of Birth _____

****

By my signature I certify that the enrollee:

1. Needs the level of care being provided and would, but for the provision of waiver services, otherwise be institutionalized in an ICF/MR;

2. Requires services to enhance functional ability or to prevent or delay the deterioration or loss of functional ability;

3. Has a significant deficit in impairment in adaptive functioning involving communication, comprehension, behavior, or activities of daily living (i.e., toileting, bathing, eating, dressing/grooming, transfer, or mobility); and

4. Requires a program of specialized supports and services provided under the supervision of a Qualified Mental Retardation Professional.

_____ _____
Name **Agency**

_____ _____
Signature **Date**

Title: [ ] Qualified Mental Retardation Professional
[ ] Registered Nurse
[ ] Physician

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

    a. informed of any feasible alternatives under the waiver; and

    b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

    a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

    b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

    c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

    d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

The Freedom of Choice documentation will be maintained by the agency designated in Appendix A as having primary authority for the daily operation of the waiver program.

FREEDOM OF CHOICE FORM

If you qualify for care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), you have the right to choose between care in your home or placement in an ICF/MR. The Medicaid Home and Community Based Services (HCBS) Waiver program provides Waiver services in your home. You may want to talk with family, friends, or others before you choose between care in your home or placement in an ICF/MR. The Division of Mental Retardation Services can provide more information about the program if needed.

Please check one of the following boxes to indicate your choice:

[ ]	**I want to be in the Medicaid HCBS MR Waiver program and get Waiver services in my home. I will have the following rights:** • **To choose any available qualified provider for my services;** • **To choose a different service provider if I am not happy; and** • **To appeal if I am not given my choice.**
[ ]	**I want to receive care in an ICF/MR facility.**

Name of Enrollee _____ Social Security Number _____

Signature of Enrollee (or Authorized Representative) _____ Date _____

Signature of DMRS Representative _____ Date _____

PROCEDURE FOR INFORMING ABOUT FEASIBLE ALTERNATIVES UNDER THE WAIVER AND FOR OFFERING FREEDOM OF CHOICE

When an individual is determined to be likely to require the level of care provided by an ICF/MR, the Administrative Lead Agency shall inform the individual or the individual's legal representative of any feasible alternatives available under the Waiver, including a description of the Waiver services, service locations, and available providers, and shall offer the choice of either institutional or Waiver services. Notice to the individual shall contain a simple explanation of the Waiver and Waiver services; a statement that participation in the Waiver is voluntary; and notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment. The Freedom of Choice form will be explained and the signature of the person to receive Medicaid Waiver services or the legal representative will be obtained on the Freedom of Choice form, which will be completed prior to admission into Medicaid Waiver services.

PROCEDURES FOR OFFERING A FAIR HEARING

1. A plain language explanation of appeal rights shall be provided to enrollees upon enrollment in the waiver.

2. The Administrative Lead Agency shall give a plain language written notice to an enrollee of any action to delay, deny, terminate, suspend, or reduce waiver services or of any action to deny choice of available qualified providers.

3. Notice must be received by the enrollee prior to the date of the proposed termination, suspension, or reduction of waiver services unless one of the exceptions exists under 42 CFR 431.211-214.

4. An enrollee has the right to appeal the adverse action and to request a fair hearing.

5. Appeals must be submitted to the Bureau of TennCare within thirty (30) calendar days of receipt of notice of the adverse action. Receipt of any notice shall be presumed to be within five (5) calendar days of the mailing date.

6. Reasonable accommodations shall be made for persons with disabilities who require assistance with the appeal process.

7. Hearings shall be held pursuant to the provisions of the Tennessee Uniform Administrative Procedures Act and shall be held before an impartial hearing officer or administrative judge.

8. A written hearing decision shall be issued within ninety (90) calendar days from the date the appeal is received. If the hearing decision is not issued by the 90th day, the waiver service may under specified circumstances be provided until an order is issued.

9. Waiver services shall continue until an initial hearing decision if the enrollee appeals and requests continuation of waiver services within ten (10) calendar days or five (5) calendar days, as applicable under 42 CFR 431.213-214 and 431.231, of the receipt of the notice of action to suspend or reduce ongoing waiver services. If the denial decision is sustained by the hearing, recovery procedures may be instituted against the enrollee to recoup the cost of any waiver services furnished solely by reason of the continuation of services due to the appeal.

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

____ Registered nurse, licensed to practice in the State

____ Licensed practical or vocational nurse, acting within the scope of practice under State law

____ Physician (M.D. or D.O.) licensed to practice in the State

____ Social Worker (qualifications attached to this Appendix)

_X_ ~~Case Manager~~ Support Coordinator

____ Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

____ At the Medicaid agency central office

____ At the Medicaid agency county/regional offices

_X_ By ~~case managers~~ Support Coordinators

____ By the agency specified in Appendix A

____ By consumers

____ Other (specify):

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

____ Every 3 months

____ Every 6 months

_X_ Every 12 months

____ Other (specify):

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

Plans of Care for persons receiving Waiver services will be subject to the approval of the Bureau of TennCare (the State Medicaid agency). The Bureau of TennCare will review a sample of the Plans of Care for individuals receiving Waiver services during the annual state assessment. Additional information may be requested by the Bureau of TennCare at any time.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

   _X_ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

   ____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

   ____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

   ____ Other (Describe in detail):

b. BILLING PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

   a. When the individual was eligible for Medicaid waiver payment on the date of service;

   b. When the service was included in the approved plan of care;

   c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

   _X_ Yes

   ____ No. These services are not included in this waiver.

   Billing Process:

   Providers submit claims for reimbursement of services rendered to the Division of Mental Retardation Services (DMRS). Each claim is reviewed to ensure that the request for reimbursement is for authorized services and is processed for payment. DMRS then submits claims electronically to the TennCare–approved fiscal agent for adjudication and payment through the MMIS. Providers who voluntarily reassign payment rights to the Division of Mental Retardation Services will receive the total reimbursed payment made by TennCare to DMRS.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

   _X_ All claims are processed through an approved MMIS.

   ____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

____ The Medicaid agency will make payments directly to providers of waiver services.

__X__ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

__X__ Providers may voluntarily reassign their right to direct payments to the following governmental agencies (specify):

Division of Mental Retardation Services

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

TennCare will enroll the providers and will pay them through the same fiscal agent used in the rest of the Medicaid program.

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1

COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	$157,541.77	$804.12	*$167,206.28	$3,200.50
2	***$219,248.76	$1,831.63	**$232,792.00	$3,200.50
3	++$185,240.25	$2,003.62	**$239,775.76	$3,501.03
4	$200,992.76	$2,191.76	**$246,969.03	$3,829.77
5	$212,790.64	$2,397.57	**$254,378.10	$4,189.39

* Factor G reflects costs for persons residing at Arlington Developmental Center for the period 7/1/2002 through 6/30/2003.

** Factor G reflects costs for persons residing at Arlington Developmental Center for the period 7/1/2003 through 6/30/2004.

*** Annualized from the 6-month budget ($109,624.38 x 2 = $219,248.76)

++ Annualized from the 8-month budget ($123,493.50 / 2 = $61,746.75; $61,746.75 x 3 = $185,240.25)

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	209
2	244
3	324
4	334
5	344

EXPLANATION OF FACTOR C:

Check one:

____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

_X_ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2

METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2

FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

	FY starting 1/1/05		FY starting 1/1/06		FY starting 1/1/07		FY starting 1/1/08		FY starting 1/1/09	
WAIVER YEAR	**1**	**X**	**2**		**3**		**4**		**5**	

Waiver Service		**Type of Unit**	**Number Undup. Users**	**Average # Annual Units/ User**	**Average Unit Cost**	**Total**
Column A			**Column B**	**Column C**	**Column D**	**Column E**
Behavioral Respite Services						
		Day	2	25	$482.00	$24,100.00
Behavior Services						
	Psychiatrist	Evaluation	2	1	$500.00	$1,000.00
	Psychologist	Evaluation	3	1	$300.00	$900.00
	Behavior Analyst	Hour	90	90	$74.75	$605,475.00
	Behavior Specialist	Hour	35	130	$26.75	$121,712.50
Day Services						
	Facility-Based Day					
	Level 1	Day	0	160	$30.00	$0
	Level 2	Day	17	160	$38.00	$103,360.00
	Level 3	Day	28	160	$51.00	$228,480.00
	Level 4	Day	10	160	$73.00	$116,800.00
	Level 5	Day	20	160	$123.00	$393,600.00
	Community-Based Day					
	Level 1	Day	102	190	$58.00	$1,124,040.00
	Level 2	Day	40	190	$90.00	$684,000.00
	Level 3	Day	28	190	$125.00	$665,000.00
	Supported Employment					
	Level 1	Day	0	160	$44.00	$0
	Level 2	Day	15	160	$75.00	$180,000.00
	Level 3	Day	10	160	$105.00	$168,000.00
	Level 4	Day	5	80	$125.00	$50,000.00
	Level 5	Month	1	12	$338.00	$4,056.00
Dental Services						
		Procedure	45	10	$80.00	$36,000.00
Environmental Accessibility Modifications						
		Modification	10	1	$5,000	$50,000.00

Waiver Service		Type of Unit	Number Undup. Users	Average # Annual Units/ User	Average Unit Cost	Total
Family Model Residential Support						
	Rate 1	Day	0	345	$42.50	$0
	Rate 2	Day	0	345	$50.00	$0
	Rate 3	Day	0	345	$69.50	$0
	Rate 4	Day	0	345	$112.00	$0
	Rate 5	Day	1	345	$217.00	$74,865.00
Individual Transportation Services						
		Day	5	250	$7.07	$8,837.50
Medical Residential Services						
	Rate 1	Day	0	245	$597.00	$0
	Rate 2	Day	1	245	$444.00	$108,780.00
	Rate 3	Day	6	245	$337.00	$495,390.00
	Rate 4	Day	9	245	$247.00	$544,635.00
	Rate 5	Day	0	245	$193.00	$0
	Rate 6	Day	0	245	$111.00	$0
	Special Adjustment	Day	3	115	$60.00	$20,700.00
Nursing Services						
	RN	Hour	5	275	$33.70	$46,337.50
	LPN	Hour	135	400	$23.75	$1,282,500.00
Nutrition						
	Assessment Rate 1	15 minutes	50	25	$12.95	$16,187.50
	Assessment Rate 2	15 minutes	1	25	$17.25	$431.25
	Assessment Rate 3	15 minutes	0	25	$19.40	$0
	Other Service Rate 1	15 minutes	50	75	$12.95	$48,562.50
	Other Service Rate 2	15 minutes	1	75	$17.25	$1,293.75
	Other Service Rate 3	15 minutes	0	75	$19.40	$0
Occupational Therapy						
	Assessment Rate 1	15 minutes	150	25	$18.00	$67,500.00
	Assessment Rate 2	15 minutes	3	25	$24.00	$1,800.00
	Assessment Rate 3	15 minutes	1	25	$27.00	$675.00
	Therapy Rate 1	15 minutes	150	325	$18.00	$877,500.00
	Therapy Rate 2	15 minutes	3	325	$24.00	$23,400.00
	Therapy Rate 3	15 minutes	1	325	$27.00	$8,775.00
Orientation and Mobility Training						
	Assessment Rate 1	15 minutes	5	25	$16.25	$2,031.25
	Assessment Rate 2	15 minutes	1	25	$21.25	$531.25
	Assessment Rate 3	15 minutes	0	25	$24.25	$0
	Other Service Rate 1	15 minutes	5	175	$16.25	$14,218.75
	Other Service Rate 2	15 minutes	1	175	$21.25	$3,718.75
	Other Service Rate 3	15 minutes	0	175	$24.25	$0

Waiver Service		Type of Unit	Number Undup. Users	Average # Annual Units/ User	Average Unit Cost	Total
Personal Assistance						
	Hour Rate – 1 staff	Hour	2	1890	$14.50	$54,810.00
	Enhanced Rate – 1 staff	Hour	2	4000	$16.50	$132,000.00
	Hour Rate – 2 staff	Hour	2	1581	$26.00	$82,212.00
	PA Rate 1	Day	2	50	$190.00	$19,000.00
	PA Rate 2	Day	2	150	$225.00	$67,500.00
Personal Emergency Response System						
	Installation/Testing	Event	8	1	$200.00	$1,600.00
	Monitoring	Month	8	8	$100.00	$6,400.00
Physical Therapy						
	Assessment Rate 1	15 minutes	135	25	$18.75	$63,281.25
	Assessment Rate 2	15 minutes	3	25	$25.00	$1,875.00
	Assessment Rate 3	15 minutes	1	25	$28.00	$700.00
	Therapy Rate 1	15 minutes	135	325	$18.75	$822,656.25
	Therapy Rate 2	15 minutes	3	325	$25.00	$24,375.00
	Therapy Rate 3	15 minutes	1	325	$28.00	$9,100.00
Residential Habilitation						
	Level 1	Day	0	345	$176.00	$0
	Level 2	Day	0	345	$206.00	$0
	Level 3	Day	1	345	$241.00	$83,145.00
	Level 4	Day	1	345	$294.00	$101,430.00
	Level 5	Day	2	345	$608.60	$419,934.00
	Special Adjustment 1	Day	1	220	$20.00	$4,400.00
	Special Adjustment 2	Day	1	220	$60.00	$13,200.00
Respite						
	Overnight					
	Level 1	Day	0	4	$62.25	$0
	Level 2	Day	1	4	$190.00	$760.00
	Level 3	Day	2	5	$225.00	$2,250.00
	Sitter					
	Hour Rate	Hour	1	60	$14.50	$870.00

Waiver Service		Type of Unit	Number Undup. Users	Average # Annual Units/ User	Average Unit Cost	Total
Specialized Medical Equipment, Supplies, and Assistive Technology						
	Equipment or Supplies					
		Item	6	1	$2000.00	$12,000.00
	Assessment/Training					
	OT Rate 1	15 Minutes	15	80	$18.00	$21,600.00
	OT Rate 2	15 Minutes	5	80	$24.00	$9,600.00
	OT Rate 3	15 Minutes	2	80	$27.00	$4,320.00
	PT Rate 1	15 Minutes	15	80	$18.75	$22,500.00
	PT Rate 2	15 Minutes	5	80	$25.00	$10,000.00
	PT Rate 3	15 Minutes	2	80	$28.00	$4,480.00
	ST Rate 1	15 Minutes	15	80	$17.25	$20,700.00
	ST Rate 2	15 Minutes	5	80	$23.00	$9,200.00
	ST Rate 3	15 Minutes	2	80	$26.00	$4,160.00
Speech, Language, and Hearing Services						
	Assessment Rate 1	15 minutes	100	25	$17.25	$43,125.00
	Assessment Rate 2	15 minutes	1	25	$23.00	$575.00
	Assessment Rate 3	15 minutes	1	25	$26.00	$650.00
	Therapy Rate 1	15 minutes	100	225	$17.25	$388,125.00
	Therapy Rate 2	15 minutes	1	225	$23.00	$5,175.00
	Therapy Rate 3	15 minutes	1	225	$26.00	$5,850.00
Support Coordination						
	Level 1	Month	209	12	$232.00	$581,856.00
Supported Living						
	Level 1	Day	0	345	$176.00	$0
	Level 2	Day	23	345	$206.00	$1,634,610.00
	Level 3	Day	117	345	$265.00	$10,696,725.00
	Level 4	Day	45	345	$482.00	$7,483,050.00
	Level 5	Day	8	345	$608.60	$1,679,736.00
	Special Adjustment	Day	15	115	$60.00	$103,500.00
Vehicle Accessibility Modifications						
		Modification	16	1	$4,000.00	$64,000.00
Vision Services						
	Evaluation	Evaluation	8	1	$200.00	$1,600.00
	Frames, Lenses, etc.	Item	8	1	$300.00	$2,400.00

Grand Total	$32,926,229.00
Total Estimated Unduplicated Recipients	209
Factor D (divide total by number of recipients)	$157,541.77
Average Length of Stay	320

APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care **or Behavioral Respite Services***, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

- Family Model Residential Support
- Medical Residential Services (if provided in a "residential habilitation" type setting)
- Residential Habilitation
- Supported Living (if provided in a home owned by the provider or affiliate)

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

- Family Model Residential Support

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

Explanation of the method used by the State to exclude Medicaid payment for room and board:

With the exception of a live-in companion for which the companion's share of room and board costs is allowed, the residential rate structure includes only staffing and program costs and excludes all room and board costs.

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

____ The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

__X__ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

Supported Living is the only service in the Waiver in which housing and food expenses of an unrelated live-in caregiver will be reimbursed provided that the recipient does not live in the caregiver's home or in a residence that is owned or leased by the provider. The housing and food expenses of the unrelated caregiver will be based on the proportionate share of the household's housing and food expenses.

APPENDIX G-5

FACTOR D'

LOC: **ICF/MR**

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D'

LOC: **ICF/MR**

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: **ICF/MR**

Factor D' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

____ Based on HCFA Form 372 for years ____ of waiver # ____, which serves a similar target population

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__X__ Other (specify):

- Waiver Year 1: Based on HCFA Form 372 for years 2002-2003 of waiver #0357, which serves a similar target population.
- Waiver Years 2-5: Based on HCFA Form 372 for years 2003-2004 of waiver #0357, which serves a similar target population.

APPENDIX G-6

FACTOR G

LOC: **ICF/MR**

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

____ Based on trends shown by HCFA Form 372 for years _____of waiver _____, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

__X__ Other (specify):

- Waiver Year 1: Based on average per capita ICF/MR institutional service expenditures for years 2002-2003 of waiver #0357.
- Waiver Years 2-5: Based on average per capita ICF/MR institutional service expenditures for years 2003-2004 of waiver #0357.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: **ICF/MR**

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

LOC: **ICF/MR**

Factor G' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

___ Based on HCFA Form 372 for years _____ of waiver_____, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__X__ Other (specify):

- Waiver Year 1: Based on HCFA Form 372 for years 2002-2003 of waiver #0357, which serves a similar target population.
- Waiver Years 2-5: Based on HCFA Form 372 for years 2003-2004 of waiver #0357, which serves a similar target population.

LOC: ICF/MR

YEAR 1

FACTOR D:	$157,541.77		FACTOR G:	$167,206.28
FACTOR D':	$804.12		FACTOR G':	$3,200.50
TOTAL	$158,345.89	≤	TOTAL	$170,406.78

YEAR 2

FACTOR D:	*$227,794.56		FACTOR G:	$232,792.00
FACTOR D':	$1,831.63		FACTOR G':	$3,200.50
TOTAL	$229,626.19	≤	TOTAL	$235,992.50

* Annualized from the 6-month budget ($113,897.28 x 2 = $227,794.56)

YEAR 3

FACTOR D:	**$185,240.25		FACTOR G:	$239,775.76
FACTOR D':	$2,003.62		FACTOR G':	$3,501.03
TOTAL	$187,243.87	≤	TOTAL	$243,276.79

** Annualized from the 8-month budget ($123,493.50 / 2 = $61,746.75; $61,746.75 x 3 = $185,240.25)

YEAR 4

FACTOR D:	$200,992.76		FACTOR G:	$246,969.03
FACTOR D':	$2,191.76		FACTOR G':	$3,829.77
TOTAL	$203,184.52	≤	TOTAL	$250,798.81

YEAR 5

FACTOR D:	$212,790.64		FACTOR G:	$254,378.10

FACTOR D':	$2,397.57		FACTOR G':	$4,189.39
TOTAL	$215,188.21	≤	TOTAL	$258,567.49

ADDENDUM TO APPENDIX G

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan/waiver. To ensure that program dollars are used only to pay for Medicaid services, we are asking states to confirm to CMS that providers retain 100 percent of the payments provided for in this HCBS waiver.

   - Do providers retain all of the Medicaid payments (including regular and any supplemental payments) including the Federal and State share, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned to the State (i.e., general fund, medical services account, etc.).

     The providers will retain all of the Medicaid payments.

2. Section 1902(a)(2)(1) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope or quality of care and services available. Similarly, Olmstead Update #4, dated January 10, 2001, indicates that "States are not allowed to place a cap on the number of enrollees who may receive a particular service within a waiver."

   - Please describe how the state share of each type of Medicaid payment in the financial estimates provided in the waiver (including regular and any supplemental payments) is funded.

     State appropriations from the legislature

   - Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share.

     State appropriations from the legislature

   - Please provide an estimate of total expenditures and State share amounts for each type of Medicaid payment. If any of the state share is being provided through the use of local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

     Projection for Year 2

     Total: $26,424,168.85 State: $9,521,949.25 Federal: $16,902,219.60

     All program growth related to Tennessee's Home and Community Based Services Waiver for the Mentally Retarded (waiver control #0357) is subject to the availability of funding as appropriated by General Assembly of the state of Tennessee. Assumptions of growth in services and enrollment are meant to be a projection.

FY 2007	Actual	FY 2008 Actual
Total	$58,085,306.47	$64,876,472.86
State	$21,064,636.39	$23,527,452.88
Federal	$37,020,670.08	$41,349,019.98

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver.

- If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type in the waiver.

Not applicable

4. If any public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of services, does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Not applicable